MACRA 101 for Hematologists

November 15, 2016

©2016, American Society of Hematology. All rights reserved.
Moderator:

Joseph Alvarnas, MD
City of Hope National Medical Center
Duarte, CA
Chair, ASH Committee on Practice

Speaker:

Erika Miller, JD
Cavarocchi – Ruscio – Dennis Associates, LLC,
Washington, DC
ASH Consultant
Learning objectives

• This webinar will relay important information about the new MACRA Rule and will provide access to an expert to provide insight on what MACRA means for hematologists.

• The objective is to provide an overview of the final rule and its impact on hematology, as well as outline the compliance implications for ASH’s clinical practice members.
Submitting questions

• Please use the chat box at the bottom of your screen to send in a question or comment to the presenters.
• Please provide your affiliation when texting questions for the presenters.
• The moderator will select questions to be answered and submit these to the presenters.
• Please submit questions as they arise. You do not have to wait for the Q&A session to pose a question.
Technical difficulties

• If you experience technical problems during the webinar, notify us via the chat box, and staff will provide assistance.
• If you get disconnected, please use the link sent to you via e-mail to reconnect.
Disclosures & recording

- Conflict-of-interest disclosures for each speaker will be presented prior to each presentation.
- A recording of this webinar will be made available on ASH On Demand (www.ashondemand.org), ASH’s multimedia platform for on-demand viewing of its educational meetings and webinars.
Agenda

- **Introductory Remarks**: Joseph Alvarnas, MD
- **Presentation**: Erika Miller, JD
- **Question & Answer Session**: Moderated by Dr. Alvarnas

*This webinar will be approximately 1 hour in duration.*
Disclosures for:

Joseph Alvarnas, MD

In compliance with ACCME policy, ASH requires the following disclosures to the session audience:

• **Honoraria:** American Journal of Managed Care/Evidence-Based Oncology, National Comprehensive Cancer Networks, Ultimate Med Learning Company

• **Membership on an entity’s Board of Directors or advisory committees:** Juno Therapeutics
Joseph Alvarnas, MD
City of Hope National Medical Center
Duarte, CA
Chair, ASH Committee on Practice

Introductory Remarks
MACRA Overview

• In the MACRA final rule, CMS verified that the ultimate goal of this program is to push providers away from fee-for-service and toward pay-for-performance
• MACRA is not an administratively created program, it was the legislated fix of the sustainable growth rate (SGR) methodology
  — MACRA is inescapable
• Final rule published October 14, 2016
• New approach to payment called the Quality Payment Program
• Performance assessed either for individual practitioners or for a group of practitioners who work under a common TIN (most pursing the latter)
• In final rule, the push to get most practitioners into an advanced APM is made explicit
• Both MIPS and advanced APMS will require robust quality data to ensure the effectiveness of provider performance under both constructs
• Presents key challenges for hematology practitioners, free standing cancer centers, and academic cancer centers (Comparator group disparity in assessing performance and cost structure of performance)
Disclosures for:

Erika Miller, JD

In compliance with ACCME policy, ASH requires the following disclosures to the session audience:

• Nothing to disclose
MACRA: What Hematologists Need to Know?

Presented by Erika Miller, Senior Vice President & Counsel, Cavarocchi – Ruscio – Dennis Associates, LLC
What is MACRA?

- Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) in April 2015
- MACRA repealed the SGR and replaced it with a new payment system called the Quality Payment Program (QPP).
- Will be implemented on January 1, 2017
- 2017 is the reporting year and 2019 is the performance year

Quality Payment Program
Eligible Clinicians will choose a path

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models
Goals for MACRA

- Simplify administrative processes for physicians
- Reduce regulatory burdens
- Promote physician flexibility and choice
- Reimburse physicians for value, not volume
## MIPS versus Advanced APMs

<table>
<thead>
<tr>
<th></th>
<th>MIPS</th>
<th>Advanced APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bonuses and Penalties</strong></td>
<td>+/- 4 percent beginning in 2019; Increases to +/- 9 percent by 2022</td>
<td>All penalties based on the terms of the APMs</td>
</tr>
</tbody>
</table>
| **Bonus Payments**     | • Providers with a MIPS score in the top 25 percent receive additional payment adjustment of up to 10 percent  
                        | • Available during 2019-24                                              | 5 percent bonus available 2019-24                                            |
| **Annual Fee Schedule Update** | 0.25 percent beginning in 2026                                      | 0.75 percent beginning in 2026                                              |
Pick Your Pace: CMS Makes 2017 a Transition Year

Avoid a Penalty

• Report one quality measure OR one improvement activity OR all 5 Advancing Care Information base measures

Full Reporting

• Report all of the required measures for a minimum of a continuous 90-day period, a full year, or anything in between. Those who choose this option will be eligible for a bonus depending on their score.

Partial Reporting

• Report MIPS data for a minimum of a continuous 90-day period. Clinicians using this option will receive either no adjustment or a small positive payment adjustment depending on their performance.

Participate in an Advanced APM
Final Rule Policies to Ease Transition

- Pick your pace reporting – only those who report nothing will be subject to 4 percent penalty in first year
- Advancing Care Information requirement reduced from full year reporting to 90 days
- Low volume threshold expanded
- Relaxed requirements for Advanced APMs – particularly regarding nominal risk
**MIPS/APM Timeline for 2019 Payment Year**

<table>
<thead>
<tr>
<th>2017 Reporting Year</th>
<th>2018</th>
<th>2019 Payment Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reporting year for the 2019 payment year</td>
<td>• March 31: Data submission deadline for MIPS</td>
<td>• Bonuses and penalties for 2017 MIPS reporting applied</td>
</tr>
<tr>
<td>• Choose to participate in MIPS or as an Advanced APM</td>
<td>• Physicians participating in MIPS will receive performance feedback</td>
<td>• Advanced APM bonuses distributed based on 2017 arrangements</td>
</tr>
<tr>
<td></td>
<td>• Data is submitted by the Advanced APM</td>
<td></td>
</tr>
</tbody>
</table>

• **Check with your practice manager to determine how you will be participating in either MIPS or an Advanced APM and what you will be expected to report**
• CMS is exploring ways to shorten the period between the reporting year and the payment year and provide more frequent feedback
MERIT-BASED INCENTIVE PAYMENT SYSTEM

What hematologists need to know
# MIPS Performance Categories and Full Reporting Requirements

<table>
<thead>
<tr>
<th>Requirements</th>
<th>2019 Weight</th>
<th>2020 Weight</th>
<th>2021 Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6 quality measures (including outcome measure) or 1 measure set (if no outcome measures are available in the measures set, report another high priority measure)</td>
<td>60%</td>
<td>50%</td>
<td>30%</td>
</tr>
<tr>
<td>• Requires reporting on 50 percent of patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Advancing Care Information</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5 base score measures</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>• Performance score measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Opportunity to report additional measures for bonus points</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Practice Improvement Activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 4 medium weighted measures OR</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>• 2 high weighted measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No additional reporting required</td>
<td>0%</td>
<td>10%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**NOTE:** In 2017, providers can report 1 quality measure, the 5 ACI base score measures, OR 1 improvement activity and avoid the penalty in 2019.
Quality Category Basics

**Reporting Requirements**
- Report 6 quality measures (1 outcome or “high priority measure) OR
- Specialty/subspecialty measures set; there is no measures set for hematology/oncology at this time

**Hematology-Specific Measures**
- Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
- Hematology: Multiple Myeloma: Treatment with Bisphosphonates
- Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
- Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

**Other Important Information**
- Bonus points will be awarded for reporting outcome and patient experience measures.
- Visit [https://qpp.cms.gov/measures/quality](https://qpp.cms.gov/measures/quality) to explore all measures in this component
Advancing Care Information Basics

**Reporting Requirements**
- Report the 5 base measures for the base score for 90 days
- Performance category score will be earned from a combination of performance in measures of provider’s choosing and/or bonus points
- This component was formerly known as Meaningful Use, and these measures have carried over

**Required Base Score Measures**
- Security Risk Analysis
- E-Prescribing
- Providing Patient Access
- Sending Summaries of Care
- Request/Acceptance of Summary of Care

**Major Changes**
- Reporting requirement was reduced from 11 to 5 measures
- Reporting will be required for 90-days, not full year as proposed
- Unlike Meaningful Use program, reporting will not be scored on “all or nothing” basis
Clinical Practice Improvement Activities

**Reporting Requirement**
- Attest on the completion of a minimum of four activities for 90 days.
- Activities are either given a weight of high or medium

**Categories of Activities**
- Expanded practice access
- Population management
- Care coordination
- Beneficiary engagement
- Patient safety and practice assessment
- Participation in an APM
- Achieving Health Equity
- Integrating behavioral and mental health
- Emergency preparedness and response

**Flexibilities**
- Groups of 15 or fewer or those in a rural or health professional shortage area must attest to the completion of 2 activities over 90 days
- PCMH or comparable specialty practices will earn full credit
- Those in the OCM will automatically receive points based on the participation in the APM
Cost

- Assessment in this category, which begins in 2018, does not require any reporting
- Physicians will be scored on their Medicare claims data
- Measures that will be applied were previously in the VBM or reported in the QRUR, but scoring is different
- Cost measures
  - Medicare Spending Per Beneficiary
  - Total Per-Capita Cost for All Attributed Beneficiaries
Example of Full MIPS Participation for a Hematologist

Sample Quality Measures

- Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
- Hematology: Multiple Myeloma: Treatment with Bisphosphonates
- Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
- Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
- Patient Safety: Documentation of Current Medications in the Medical Record
- Effective Clinical Care: Proportion Receiving Chemotherapy in the Last 14 Days of Life

Sample Improvement Activities

- Implementation of regular reviews of targeted patient population needs
- Provide episodic care management, including management across transitions and referrals
- Implementation of practices/processes to develop regularly updated individual care plans for at-risk patients
- Engage patients, family and caregivers in developing a plan of care and prioritizing their goals for action, documented in the EHR

Sample Advancing Care Information Measures

- Electronic Prescribing
- Patient Electronic Access
- Security Risk Analysis
- Sending Summaries of Care
- Request/Acceptance of Summary of Care
Areas for Future Measures Development

ASH will explore developing measures on topics where it has developed clinical practice guidelines.

Current guideline projects include:

– Venous Thromboembolism (VTE)
– Sickle Cell Disease
– Initial Workup of Acute Leukemia
– Immune Thrombocytopenia (ITP)
ALTERNATIVE PAYMENT MODELS
What is an APM?

- Alternative Payment Models (APMs) are new approaches for Medicare to pay for medical care that incentivize quality and value.
- APMs can apply to specific clinical conditions, a care episode, or a population.
- May offer significant opportunities to clinicians who are not immediately able or prepared to take on the additional risk requirements of Advanced APMs.
Types of APMs

- Advanced APM
- MIPS APM
- Qualified Medical Homes
- Other Payer Advanced APMs
MIPS APMs: Reporting and Scoring

- Generally
  - Streamlined MIPS reporting and scoring
  - Aggregates eligible clinician MIPS scores to the APM entity level
  - All eligible clinicians in an APM entity receive the same MIPS final score
- Benefits
  - Receiving at least half of the maximum Improvement Activity credit depending on the APM model
  - Ability to use quality reporting in the APM to meet the MIPS quality reporting requirement
  - Cost category weighting will remain at zero until changed by future rulemaking
- Qualifying MIPS APM Models
  - Oncology Care Model (all arrangements)
  - Shared Savings Program Tracks 1, 2, and 3
  - Next Generation ACO Model
  - CPC+
  - Comprehensive ESRD Care Model (all arrangements)
Advanced APM Overview

All Advanced APMs meet the following three criteria in the 2019 and 2020 payment years.

1. Meet quality reporting requirements comparable to those in MIPS
   • Measures must be evidence-based, reliable, and valid and at least one must be an outcomes measure

2. Meet certified electronic health record technology use requirements
   • At least 50 percent of the clinicians in each APM entity must use CEHRT

3. Must bear more than a nominal amount of financial risk
What is more than nominal amount of financial risk?

Financial Risk

The Advanced APM may do one or more of the following if actual expenditures exceed expected expenditures:
- Withhold payment for services to the APM Entity and/or the APM Entity’s eligible clinicians;
- Reduce payment rates to the APM Entity and/or the APM Entity’s eligible clinicians;
- Require direct payments by the APM Entity to CMS.

Total Amount of Risk

The total amount of risk must be equal to at least either:
- 8% of the average estimated total Medicare Parts A and B revenues of participating APM entities; OR
- 3% of the expected expenditures for which an APM Entity is responsible under the APM.
Qualifying APM Participants (QPs)

QPs are clinicians who have a certain percentage of Part B payments or patients through an Advanced APM. Beginning in 2021, the threshold percentage may be reached through a combination of Medicare and other non-Medicare payer arrangements.

(For 2021-22 and 2023 and Beyond, the figures below are for the all payer track)

<table>
<thead>
<tr>
<th>Status</th>
<th>Threshold</th>
<th>2019-20</th>
<th>2021-22</th>
<th>2023 and Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifying Participant</td>
<td>Payment</td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>20%</td>
<td>35%</td>
<td>50%</td>
</tr>
<tr>
<td>Partial Qualifying Participant</td>
<td>Payment</td>
<td>20%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>10%</td>
<td>25%</td>
<td>35%</td>
</tr>
</tbody>
</table>

If an individual eligible clinician who participates in multiple Advanced APMs does not achieve QP status through participation in a single advanced APM, CMS will determine QP status based on combined participation in multiple advanced APMs.
2017 Advanced APMs

- Oncology Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus
- Comprehensive ESRD Care Model (Two-Sided Risk Arrangements)
- Shared Savings Program Track 2
- Shared Savings Program Track 3
- Next Generation ACO Model
Other Payer Advanced APMs

- Criteria for these Advanced APMs will be similar to those for Advanced APMs
- Only fall into this category if do not meet the QP threshold under the Medicare only option
- Only becomes an option in the 3rd year of the program
- Payments from the following programs are excluded from these calculations:
  - DOD Health Care Programs
  - Department of Veterans Affairs Health Care Program
  - Title XIX in a state with no Medicaid Medical Home Model or APM
QP Performance Period for Advanced APMs

- During this period, CMS will assess eligible clinicians’ participation in Advanced APMs to determine if they will be QPs for the payment year.
- Performance period will be January 1-August 31 of the calendar year two years prior to the payment year.
  - This is generally consistent with MIPS.
- CMS will take three “snapshots” on March 31, June 30, and August 31 to assess if the QP thresholds are met.
- Eligible clinicians will be notified of their QP status after the determination is complete.
- If not a QP, may be a “partial” QP and have a choice whether to participate in MIPS.
Physician-Focused Payment Model Technical Advisory Committee (PTAC)

• MACRA established the PTAC to review and assess Physician-Focused Payment Models based on proposals submitted by stakeholders to the committee

• How the PTAC works

<table>
<thead>
<tr>
<th>Proposed model is submitted to the PTAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTAC reviews and provides comments and recommendations on the proposals to the Secretary</td>
</tr>
<tr>
<td>Secretary of HHS reviews the recommendations of PTAC and posts a detailed response on the CMS website</td>
</tr>
<tr>
<td>Models that receive a favorable response will go to the Innovation Center</td>
</tr>
<tr>
<td>Models that are implemented will go through the CMS development process for APMS</td>
</tr>
</tbody>
</table>
Preparing for 2017

- Check with your practice manager to determine how you will be participating in either MIPS or an Advanced APM and what you will be expected to report
- Avoid a penalty - Report one quality measure **OR** one improvement activity **OR** all 5 Advancing Care Information base measures

<table>
<thead>
<tr>
<th>Potential Quality Measures to Report on</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry</td>
</tr>
<tr>
<td>Hematology: Multiple Myeloma: Treatment with Bisphosphonates</td>
</tr>
<tr>
<td>Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow</td>
</tr>
<tr>
<td>Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy</td>
</tr>
</tbody>
</table>
Question-and-answer session

Moderated by: Joseph Alvarnas, MD

You will be redirected to a short survey at the end of this webinar. Your feedback is very helpful to ASH in developing future webinars. Thank you for your participation.

Visit ASH On Demand (www.ashondemand.org) to access recordings of ASH webinars and meeting webcasts.

©2016, American Society of Hematology. All rights reserved.